



PATIENT REGISTRATION FORM

_____ ()

Date ____/____/____
Patient Name _____ () Sex ____ Home Phone _____
Email Address _____ Cell Phone _____
Birthdate: Mo. ____ Day ____ Year ____ Age ____ Marital Status ____ Number of Children ____
Address _____
City _____ State ____ Zip ____
Occupation ____ Employer ____ Work Phone ____
Referring Dr. or Other Source ____ Family Dr. ____
Name & Address of Closest Relative Other Than Spouse _____
Relationship ____ Telephone ____

PRINCIPAL REASON FOR THIS APPOINTMENT

INSURANCE AND BILLING INFORMATION

Please bring insurance cards to the window when you return this form.

Spouse or Person Responsible for Bill _____ Relationship _____
Address (if different) _____ Employer _____
Occupation _____
City _____ State ____ Zip ____ Work Phone _____
1st Insurance Co. _____
Policy Holders' Name: _____ Relationship to Patient _____
Policy Holders' SS# _____ DOB _____
Policy Number _____ Group No. _____
2nd Insurance Co. _____
Policy Holders' Name: _____ Relationship to Patient: _____
Policy Holders' SS# _____ DOB _____
Policy Number _____ Group No. _____
3rd Insurance Co. _____
Policy Holders' Name: _____ Relationship to Patient: _____
Policy Holders' SS# _____ DOB _____
Policy Number _____ Group No. _____

PLEASE READ THE INFORMATION BELOW AND SIGN

I hereby apply for treatment by the above physicians, their associates and/or assistants. Treatment may include injections and/or such other office procedures they deem necessary.
I authorize the release of information necessary for the filing of any insurance and the direct payment to the above physicians of any amounts due on my claim under the above stated policies or any policy that I may at a later date ask to be filed.
I accept responsibility for payment of all charges incurred as well as attorney's fees of 33 1/3% and any other related costs of collection should such action become necessary.

Signature: _____

Name _____ Age _____ Chart # _____
 Social Security # _____ Referred by _____
 New Updated Data _____ Date _____
 Reason For Today's Visit _____ Family Physician _____

PREVIOUS SURGERY

Have you ever been operated on for any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Colonoscopy/BE _____ Date _____ | <input type="checkbox"/> Heart Surgery _____ Date _____ |
| <input type="checkbox"/> Appendectomy _____ Date _____ | <input type="checkbox"/> Breast Surgery _____ Date _____ |
| <input type="checkbox"/> Hysterectomy _____ Date _____ | <input type="checkbox"/> Hernias _____ Date _____ |
| <input type="checkbox"/> Gallbladder _____ Date _____ | <input type="checkbox"/> Hemorrhoidectomy _____ Date _____ |
| <input type="checkbox"/> Colon _____ Date _____ | <input type="checkbox"/> Tonsils _____ Date _____ |
| <input type="checkbox"/> Vascular Surgery _____ Date _____ | <input type="checkbox"/> Laparoscopy _____ Date _____ |

Others: _____

Remarks: _____

If necessary, would you agree to blood or blood products? Yes No

MEDICAL HISTORY

Do you or any family members have a history of any of the following?

	Yourself	Family		Yourself	Family
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (Other)	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Colon Disease	<input type="checkbox"/>	<input type="checkbox"/>	Others	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>			

ALLERGIES TO MEDICATIONS (Please List medicine with symptoms)

MEDICATIONS (Please check) Aspirin Steroids Coumadin

Are you now taking any other medications? Yes No

Medicine Name	Dosage	How many times a day?
_____	_____	_____
_____	_____	_____

Do you smoke? Yes No How much? _____ How long? _____

Do you drink alcohol? Yes No How much? _____ How long? _____

Do you use caffeine? Yes No How much? _____

Do you wear glasses? Yes No Contacts? Yes No Hearing Aid? Yes No Dentures? Yes No

FOR FEMALES

Date of last period _____ Last Mammogram? _____ Menopause

How many pregnancies? _____ How many children? _____ Breastfeed Yes No

Last pap smear _____ Type of Birth Control _____

Authorization for Release of Insurance

Date: _____

I am interested in having surgery with Sentara Norfolk General Hospital and Sentara Metabolic & Weight Loss Surgery Center . Therefore, I would like you to release any information to determine eligibility, benefits, co-payments or any out-of-pocket expenses.

I also give permission for any insurance company to inform Sentara Norfolk General Hospital and Sentara Metabolic & Weight Loss Surgery Center of the reasonable and customary reimbursements for my surgical procedure.

Signature _____

Print Name _____